Oxygen saturation in pregnant individuals with COVID-19: time for re-appraisal?

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Introduction and Current Guidelines

During pregnancy, several professional societies recommend maintaining O₂ saturation (SpO₂) at ≥95%.

Managing pregnant individuals with acute respiratory disease secondary to COVID-19 has been a challenge. Most professional societies including the Society for Maternal-Fetal Medicine recommend keeping O₂ saturation at ≥95% in pregnant individuals. Reaching this target has been increasingly difficult in some patients, especially during the latest wave of infections attributed to the delta variant of SARS-CoV-2. In the absence of adequate supporting data, and in the setting of a reassuring fetal status, we propose that maternal O₂ saturation should be maintained between 92% and 96% for admitted patients with acute respiratory failure who require supplemental O₂. This may prevent unnecessary invasive interventions that might not hold maternal or fetal benefit, specifically at very preterm gestational ages.

Key words: COVID-19, oxygen saturation, pregnancy
which makes the fetus more resistant to changes in maternal O2 saturation and some degree of hypoxia.15,16 Further support that a PaO2 of 60 mm Hg is adequate for fetal O2 delivery is on the basis of data from pregnant individuals living at high altitudes.17 Although this is a chronic rather than acute exposure to hypoxia (and is accompanied by compensation such as tachypnea and relative polycythemia), most of the pregnant individuals are young and healthy and have a good reserve to tolerate even acute hypoxia.18

In an effort to decrease maternal morbidity and mortality, early warning models have been developed to assist in the timely recognition of acutely ill patients,19–21 with some models including SpO2 as one of the parameters.19,20 Unlike other vital sign parameters that could directly be associated with an increased risk for maternal morbidity, the use of SpO2 at <95% was not (relative risk, 1.3; 95% confidence interval, 0.2–7.9).19 Shields et al19 published a maternal early warning tool using different cutoffs for SpO2. They used an SpO2 of <90% as a single severe parameter and an SpO2 of <93% as a nonsevere parameter. However, low SpO2 (whether <90% or <93%) was a rare occurrence and was seen in <0.1% of included patients.20 In conclusion, the paucity of clinical data and lack of significance seen in early warning models do not provide sufficient evidence to support using an SpO2 of ≥95% as a cutoff for pregnant individuals presenting with acute respiratory distress.

**Challenges in Maintaining an O2 Saturation of ≥95%**

In nonpregnant individuals with acute respiratory failure secondary to COVID-19, current guidelines recommend starting supplemental O2 when levels drop below an SpO2 of 90% (strong recommendation, moderate-quality evidence) and suggest supplemental O2 use when SpO2 falls below 92% (weak recommendation, low-quality evidence).22 In acutely ill patients, high-quality evidence showed that liberal O2 therapy (median baseline SpO2 of 96%) is associated with increased mortality.22 Moreover, practice guidelines for acutely ill patients, including COVID-19 patients with acute hypoxemic respiratory failure, do not recommend administration of supplemental O2 above an SpO2 of 96% (strong recommendation, moderate-quality evidence) because it may lead to worse outcomes.22–24 In pregnant individuals, Pacheco et al1 also recommend that O2 therapy should be titrated to avoid SpO2 levels above 96%. Using a minimum target of 95% for SpO2 in pregnancy would make it more difficult to titrate O2 supplementation to avoid an SpO2 of >96%.

There is a paucity of data to guide the O2 goals when COVID-19 progresses to ARDS. Generally, the goal is to maintain PaO2 at 55 to 80 mm Hg on the basis of extrapolation from the original ARDSNet trial25 and more recent use in the ACURASYS16 and Reevaluation of Systemic Early Neuro-muscular Blockade27 trials. Although there may be phenotypes of COVID-19–associated ARDS that respond to high amounts of noninvasive supplemental O2 support, such as heated high-flow nasal cannulas, many of these patients will require invasive mechanical ventilation.28,29 Indeed, some emerging data suggest that noninvasive positive-pressure ventilation (continuous positive airway pressure or bi-level positive airway pressure) may increase mortality and fail to decrease the rates of intubation in critically ill COVID-19 patients.30 Other modern therapies for ARDS, such as prone positioning, have been used as alternative interventions to avoid invasive mechanical ventilation and improve oxygenation in COVID-19 patients.31,32 However, these therapies present unique challenges for pregnant individuals.

The criteria to mechanically ventilate pregnant and nonpregnant individuals are similar. These include airway protection, hypoxia, hypercarbia, and hemodynamic instability.15 Pregnant individuals infected with the SARS-CoV-2 delta variant are more frequently critically ill, requiring O2 support more often compared with infection with previous variants.33,34 In pregnant individuals with acute respiratory failure secondary to COVID-19, guidelines suggest to maintain a target maternal SpO2 of ≥95% as per professional societies recommendations, whereas for nonpregnant patients, often a target PaO2 of 55 to 80 mm Hg or an SpO2 of >90% is recommend. To meet this higher goal, pregnant individuals may need increased O2 delivery by noninvasive O2 delivery methods, earlier intubation and mechanical ventilation, increasing fraction of inspired O2, mean airway pressure, or positive end-expiratory pressure. In addition, pregnant individuals will have cephalad displacement of the diaphragm, increased intraabdominal pressure, which provides mechanical evidence of a disadvantage of oxygenation, and an increased O2 consumption by the developing fetus. This increased oxygenation target is difficult to achieve, especially in patients with COVID-19 affected by the latest wave of infections attributed to the delta variant of SARS-CoV-2.33,35 Thus, pregnant patients may be more likely to be exposed to increased invasive interventions when maternal oxygenation goals of 95% are unable to be maintained using noninvasive methods of O2 supplementation, with potential risks and without clear maternal or fetal benefit.

In its guidance for managing COVID-19 patients, the SMFM suggests delivery at or after 32 weeks’ gestation in settings of refractory maternal hypoxemia.1 Although an SpO2 cutoff of ≥95% seems reasonable and safe as a target, in most clinical situations, challenges in treating pregnant individuals affected by the most recent COVID-19 wave have raised questions regarding the validity of this recommendation, especially for patients at extreme preterm gestational ages. Designing a randomized controlled trial comparing the clinical outcomes for patients who were maintained at O2 saturation levels of 92% and 95 %, respectively, would be ideal and might be warranted. However, designing and completing such a trial in a timely fashion with the current COVID-19 wave is unrealistic. Individualized patient care based on maternal clinical
status and gestational age is of utmost importance.

External Fetal Monitoring as a Noninvasive Tool
Fetal oxygenation depends on maternal oxygenation and placental perfusion. Significant disturbances in maternal oxygenation may lead to fetal hypoxia, which is often reflected as a non-reassuring fetal status during fetal heart rate monitoring. External fetal monitoring can be used as an indicator of fetal well-being, and having a reassuring fetal heart rate is associated with adequate oxygenation and perfusion of the fetus. Fetal heart rate monitoring can be used as an additional vital sign that may help in the management of the maternal condition and guide the decision to move toward additional invasive interventions if needed. As long as the fetal status is reassuring, tolerating a maternal SpO2 between 92% and 96% is prudent and might prevent detrimental outcomes associated with invasive interventions that could negatively affect both mother and baby.

Furthermore, tolerating a lower maternal SpO2 may prevent unnecessary fetal interventions that could happen at time of intubation or extracorporeal membrane oxygenation (ECMO) cannulation, which could be challenging depending on the maternal characteristics. In many instances with difficult intubations, maternal O2 saturation can transiently drop as low as 60% to 70% and is often associated with changes in variability and decelerations on the fetal monitor. Sustained nonreassuring fetal status often warrants acute interventions such as emergent cesarean delivery, which carries significant additional morbidity to the mother on top of her acute respiratory failure secondary to COVID-19. More so, in cases of very preterm pregnancies, a classical cesarean delivery may be indicated, which carries an increased risk of bleeding and long-term implications for future pregnancies.

Conclusion
An SpO2 below 95% in a pregnant individual with COVID-19 should prompt evaluation by a healthcare provider and may require inpatient admission. For pregnant individuals on supplemental O2 for acute respiratory failure secondary to COVID-19 infection, there is a lack of convincing evidence supporting the current recommended SpO2 of ≥95%. We suggest maintaining SpO2 in a range of 92% to 96% in critically ill individuals admitted to the hospital on O2 supplementation.

In the setting of reassuring fetal heart rate monitoring, this could possibly prevent unnecessary invasive interventions including endotracheal intubation with mechanical ventilation and ECMO. This is especially significant when the decision to escalate to these measures is based on the concern for maintaining fetal oxygenation rather than supporting the mother’s respiratory status. In these situations, external fetal monitoring can be used as an additional noninvasive tool to monitor the fetal well-being and reserve invasive interventions for maternal respiratory status indications as long as the fetus is not showing signs of distress.

REFERENCES


